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SCRIPT Electronic Prior Authorization Transactions Overview

August 2013

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Prior Authorization Impacts All Healthcare

Pharmacy challenge

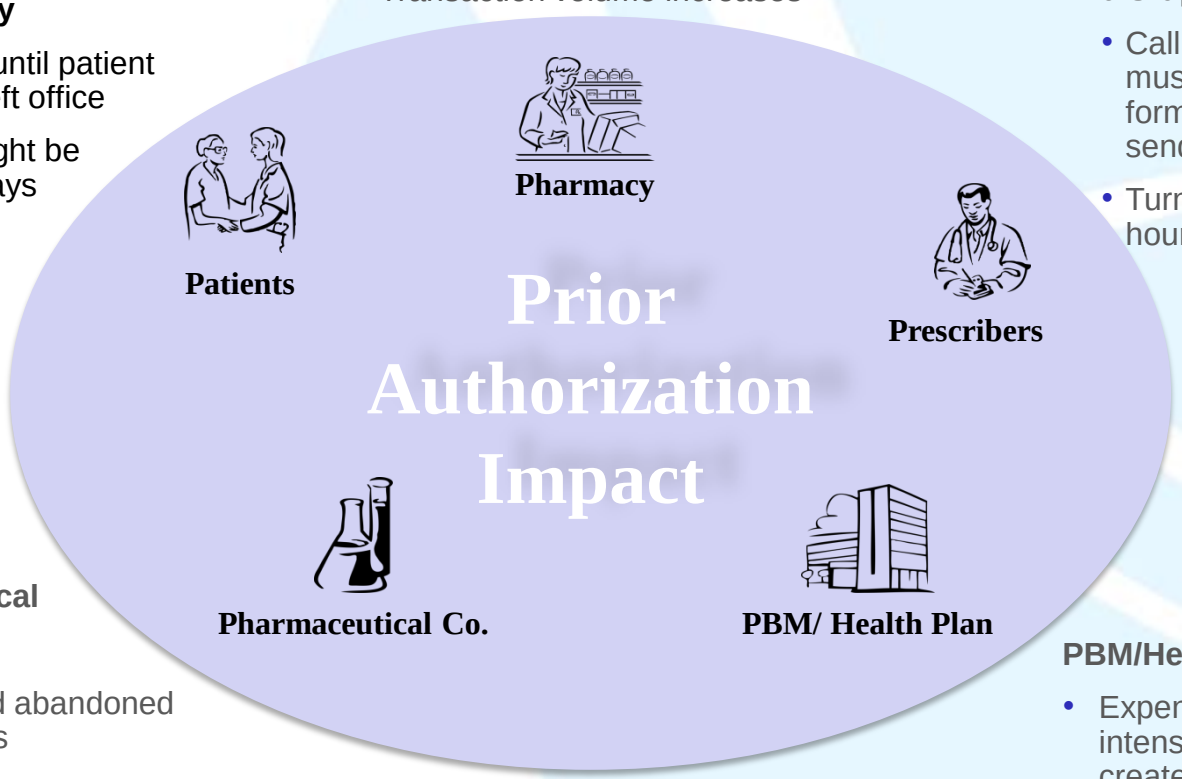
- Pharmacy call volumes increase to prescriber's office, plan, etc.
- Transaction volume increases

Patient frustration and treatment delay

- PA unknown until patient has already left office
- Treatment might be delayed for days
- Reduced satisfaction

Prescriber hassle and disruption

- Call back from pharmacy, must call plan, wait for faxed form, completes form and sends it back
- Turnaround time can be 48 hours or more



Pharmaceutical Obstacles

- Delayed and abandoned prescriptions
- Extensive outlay for physician and patient administrative assistance

PBM/Health plan inefficiency

- Expensive and labor intensive process that creates frustration

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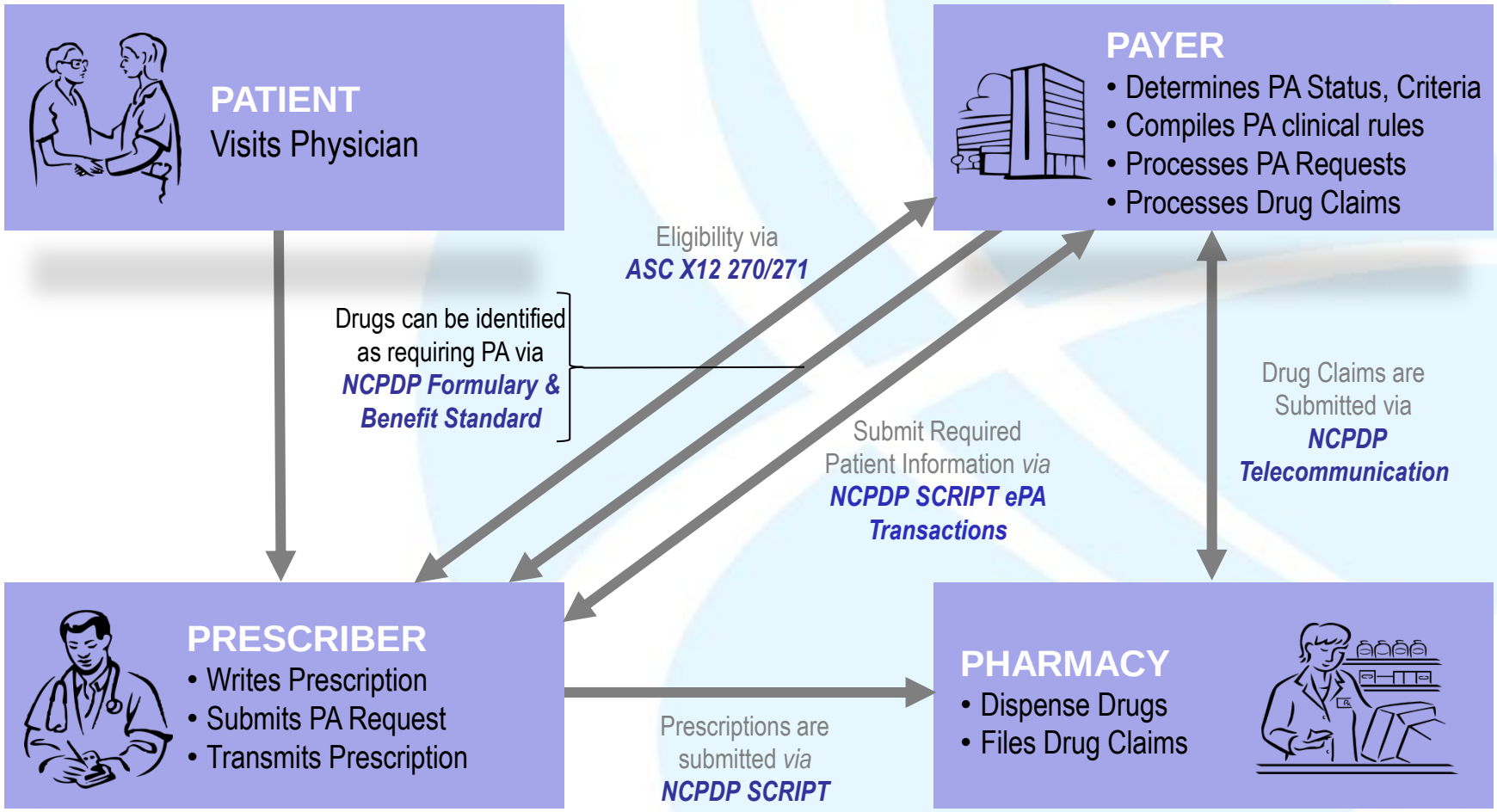
Electronic Prior Authorization Process for the Pharmacy Benefit



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Electronic Prior Authorization History

1996 — HIPAA
X12 278 named prior authorization transaction standard for non-retail pharmacy.
Telecom Standard named for retail pharmacy

2004 — NCPDP ePA Task Group Formed
Promote standardized automated PA adjudication;
gaps identified

2006 — MMA ePrescribing Pilots
Determined the X12 278 PA standard was inadequate for medications

2006 — CMS/AHRQ pushes forward
Resolution of where standard should reside
Value model created

2009 — NCPDP Creates New Transactions
Compatible with emerging technology
No pilots
HIPAA reconfirms use of X12 278 and Telecom Standard

2010 — Renewed Interest
Pilots conceived/initiated
state legislative interest

2012 — NCPDP Revises Transactions
Pilot results incorporated into revised standard

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NCPDP vs. X12 Transaction Discussion

- The WG11 Prior Authorizations Workflow to Transactions Task Group had robust discussions on the use of the NCPDP SCRIPT Standard and the ASC X12 278 for prior authorization
  - Many perspectives were heard
  - Alternatives were presented and discussed
- Straw man vote on the alternatives was held in June 2012
  - 85% of task group participants voting preferred to move ahead with the NCPDP draft transactions
- The Task Group focused on pharmacy benefit PA processing in its work
- With state mandate deadlines approaching, there was a sense of urgency to move forward with workable solutions that can evolve to include new capabilities

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SCRIPT STANDARD TRANSACTION REVIEW

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Electronic Prior Authorization Transactions Status

- Transactions added to NCPDP SCRIPT Standard
  - Reusing definitions for common elements: Header, Patient, Prescriber, Pharmacy, Medication Prescribed, Benefits Coordination
  - Reusing Attachments
  - Reusing acknowledgement transactions: Status, Verify, and Error
- NCPDP SCRIPT Standard version 2013071 published July 2013
  - Available free of charge with NCPDP membership (www.ncpdp.org)
  - SCRIPT Implementation Guide, XML schema, data dictionary and external code list
- NCPDP has been working with Department of Health and Human Services (HHS) for the naming of the electronic prior authorization transactions for the pharmacy benefit
  - HHS/OESS/CMS have been involved in all steps of the process, back to 2004
  - NCVHS issued recommendation of use to HHS
  - DSMO Change Request 1189 was filed
  - Regulatory processes underway

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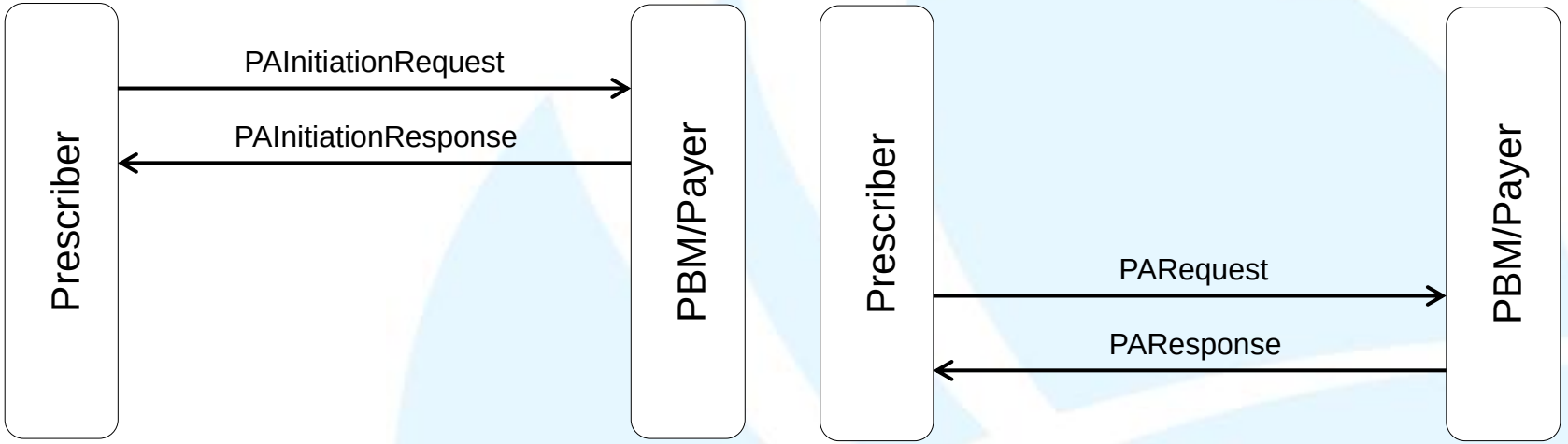
Electronic Prior Authorization Transactions

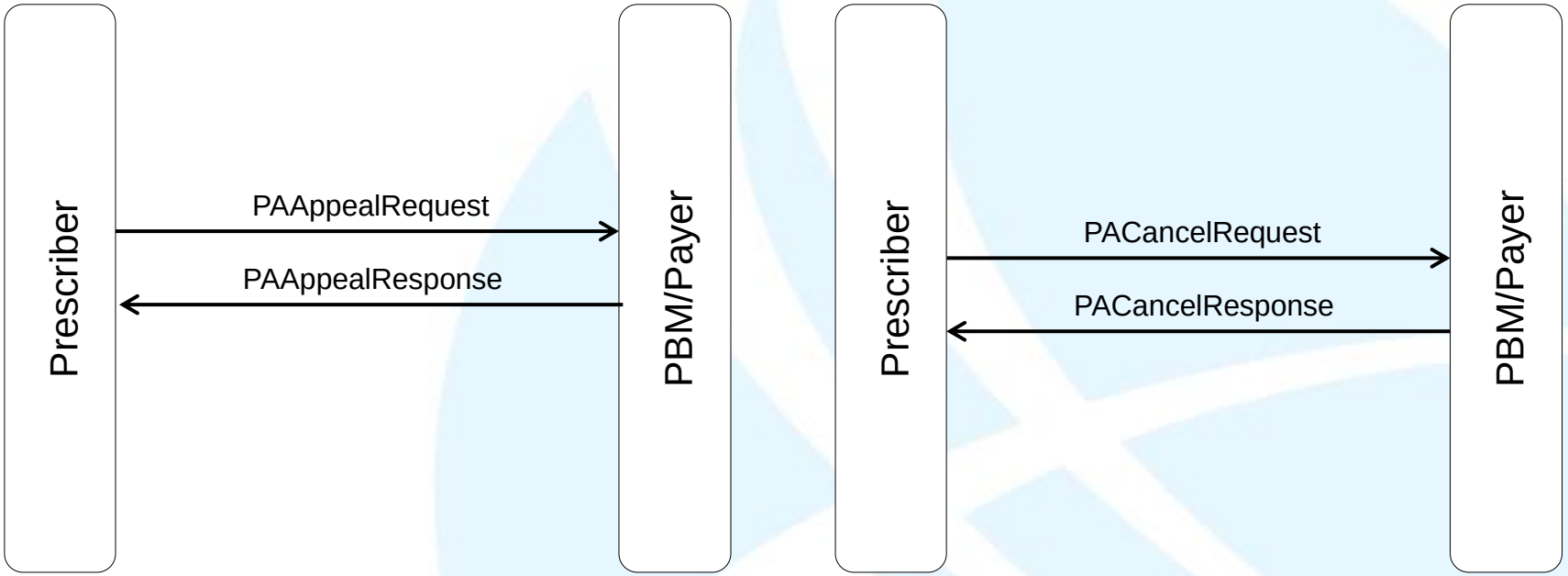
- Supports an electronic version of today's PA process (i.e., PBM/payer provides prescriber with a set of questions they must answer for PA consideration) for medication and DME products covered by pharmacy benefit
- Provides a standard structure for exchanging the PA questions and answers between prescriber and payers, while allowing for payers to customize the wording of the questions
- Additionally supports elements that allow for automation of the collection of data required for PA consideration (i.e., coded references for each question (e.g., LOINC, SNOMED, CDA template) allowing an EMR vendor to systemically pull data from patient's medical record)
- Supports both a solicited and unsolicited model

PA Transaction Overview



- PAInitiationRequest/Response (used in the solicited model only)
  - Prescriber requests the information required to accompany a PARequest for a particular patient and medication.
  - PBM/payer responds with the information required to accompany a PARequest or an indication a PA isn't required for the patient and medication.
- PARequest/Response
  - Prescriber sends the information requested in the PAInitiationResponse (solicited model) or information agreed upon outside of the PA transactions by the trading partners (unsolicited model).
  - PBM/payer responds with PA determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - Repeat request/response transactions when more info required.

PA Transaction Overview



Other Transaction functions supported:

- PAAppealRequest/Response
  - Usage of these transactions is the same as the PAInitiationRequest/Response and PARequest/Response transactions.
- PACancelRequest/Response
  - Prescriber requests a PARequest that's in process be canceled.
  - PBM/payer responds with a cancellation status.

PAInitiationRequest

Prescriber → PBM/Payer

Data Elements:

Header	to, from, message ID, date/time sent
Prescriber	ID, specialty, name, address
Patient	ID, name, address, DOB, gender
Benefits Coordination	cardholder ID/name, health plan ID, group ID
Pharmacy	ID, name, address
Medication Prescribed	ID, description-name/strength/dosage form, quantity

- Used in the solicited model only
  - Prescriber requests the information required to accompany a PARequest – what questions need to be answered, what information needs to be provided.
- Benefits Coordination information can be sent when available to be used by the PBM/payer to assist in identifying the patient's coverage.

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PAInitiationResponse

PBM/Payer → Prescriber

Data Elements:

Header	to, from, message ID, date/time sent
Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed	
Response Detail	status indicating question set provided or PA not required
Question Set Header	title/instructions to display to prescriber
Question Set Detail & Answer Choice	question/answer choice text, question type (e.g., multiple choice, numeric, date, free text), next question logic, coded reference (e.g., LOINC, SNOMED, CDA template ID) to systematically identify information required

- Used in the solicited model only
  - PBM/payer responds with the information required to accompany a PARequest
    - Information required provided as a question set (question/answers to display to prescriber) with optional support for coded references EMR can use to pull information from patient's medical chart.

  OR
  - or an indication a PA isn't required for the patient and medication
    - Specific to the patient's coverage and the medication prescribed.

PARequest

Prescriber → PBM/Payer

Data Elements:

Header	to, from, message ID, date/time sent
Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed	
Completed Question Set	answers/information provided by the prescriber or EMR (i.e., answer selected/entered by the prescriber or information populated from the patient's medical chart)
Attachment(s)	attachment type, attachment payload

- Prescriber sends the information requested in the PAInitiationResponse (solicited model) or information agreed upon outside of the PA transactions by the trading partners (unsolicited model).
- Attachments can be sent related to a specific question or for the request overall.

PAResponse

PBM/Payer → Prescriber

Data Elements:

Header	to, from, message ID, date/time sent
Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed, Completed Question Set	
Response Detail	Determination status (e.g., approved, denied, pended, more info required), details specific to the status
Attachment(s)	attachment type, attachment payload

- PBM/payer responds with PA determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - Approved status: authorization details (start/end date, quantity, # of fills)
  - Denied status: denial reason, appeals details
  - More Information Required status: Question Set identifying additional information required
- Repeat request/response transactions when more info required.
- Attachments can be sent with more information related to the status (e.g., approval/denial letter).

PAAppeal Transactions

PAAppealRequest	Prescriber → PBM/Payer
PAAppealResponse	PBM/Payer → Prescriber

- Usage and definition of these transactions is the same as the PAInitiationRequest/Response and PARequest/Response with slight modifications to support appeals
  - PAAppealRequest/Response used to request and identify the information required to accompany a PAAppealRequest.
  - PAAppealRequest/Response used to send requested information and respond with determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - PAAppealRequest/Response repeat if more information is required.

PACancel Request

Prescriber → PBM/Payer

Data Elements:

Header	to, from, message ID, date/time sent
Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed	
Cancel Detail	reason for canceling

- Prescriber sends a request to cancel a PARequest in process when PA no longer needed.
- Request includes reason from the prescriber for canceling the PARequest.

PACancel Response

PBM/Payer → Prescriber

Data Elements:

Header	to, from, message ID, date/time sent
Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed	
Response Detail	status indicating if the PA Request was canceled or not

- PBM/payer responds with status indicating if the PARequest was successfully canceled or not.

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Thank you!

Questions:

Anthony Schueth, Task Group leader

Point-of-Care Partners, LLC

tonys@pocp.com

Lynne Gilbertson

NCPDP

lgilbertson@ncpdp.org